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ABSTRACT

Demographic data suggest that alcohol abuse among the elderly will increase in proportion to the population growth of that group. Four factors which may cause the elderly to be a highly susceptible group for alcohol problems are: (1) retirement and its boredom, role changes, and financial problems; (2) increased concern with death and losses of relatives and friends; (3) poor health and chronic discomfort; and (4) loneliness, particularly among older women. Although surveys in older age groups are of questionable value, anecdotal evidence and early studies suggest that a high proportion of elderly (10-15%) who seek medical attention for any reason have an alcohol-related problem, and that elderly alcoholics are relatively easy to treat. If these findings can be confirmed, detection during health-seeking encounters could have great potential value. Research in detection and treatment is critical. A prevention strategy aimed at persons aged 55 to 64 could prevent subsequent alcohol problems among these people and might indirectly reach those at older and less accessible ages. (Author/NRB)

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THE AGING AND ALCOHOL ABUSE

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Paper presented at the White House Conference on Aging, Washington, DC, November 30 - December 3, 1981 and the Annual Meeting of the National Council on Alcoholism, Seattle, WA, May 1-7, 1980.

Abstract

Demographic information suggests that the problems of alcohol abuse among the elderly will increase at least in proportion to the population growth of that sector. While fewer older people drink and average consumption declines, four factors which promote alcohol abuse are noted. These are (1) retirement with its attendant boredom, change of role status and loss of income, (2) deaths occurring among relatives and friends and the awareness that more deaths are coming, (3) poor health and discomfort, and (4) loneliness, with a particular problem among elderly women. Surveys in older age groups, in addition to being costly are of questioned value. Anecdotal evidence and several early studies, however, suggest that a high proportion of elderly (10 to 15 percent) who seek medical attention for any reason, have an alcohol related problem and that elderly alcoholics, whether of early or recent onset are relatively easy to treat. If these findings can be confirmed than detection during health seeking encounters could have great potential value. Research in detection and treatment is critical. A prevention strategy involving the cohort 55 to 64 years of age could have the dual effect of preventing subsequent alcohol problems among these people and by offering a message that would be heard by those at older and less accessible ages.

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A Ponderable

The subtitle, "Should the use and misuse of alcohol in the aging population be a concern to the field of Alcoholism and Gerontology?" practically demands a fire and brimstone exhortation deep with heartfelt concern for the urgency of this topic. In truth, however, alcohol abuse is not the biggest problem for aging and aging is not the major concern of alcohol abuse workers. What I hope to accomplish is a thoughtful awareness that a problem exists and should be of concern to the field of alcohol and gerontology. I state this because there are so few opportunities for a sufficient amount of tangible progress to be made--and to be accomplished in a timely fashion--that I think it's incumbent upon us to get on with it.

Defining aging and the aged is difficult and beyond the scope of our discussion. I shall avoid this complicated issue by confining my remarks to the population age 65 and over. Stereotypically, for this population we conjure up a picture of the abandoned sick in decaying nursing homes throughout the land. This allows us to muster up a full measure of guilt about the sad and forsaken elderly sector of the country. In fact, however, only 5 percent of the people over age 65 are in nursing homes. The rest are out there, and for the most part, doing rather well. I shall quote from Riley and Foner (1). "The typical older person seems to have a strong sense of his own worth, to minimize his self-doubts, and not even to regard himself as old. The older person seems at least as likely as the younger person to feel adequate and to have a sense of satisfaction in playing his various marital, parental, occupational, or housekeeping roles. To be sure, he does not perceive old age as the

happiest period of his life. Nevertheless, he does not worry any more than the young person about his health, his finances, or any of the other difficulties to which he is subject." Having thus with some smugness said that most of our notions on the aged are misconceptions and stereotypes, let me turn to another aspect of aging. I will attempt another quote—this from the Elisabeth Kubler-Ross book "On Death and Dying" (2). In a sense capturing the wit and wisdom of Kubler-Ross, we have this remarkable statement ". . . we are impressed that death has always been distasteful to man and will probably always be."

Thus, we have a theme to ponder from the statements by these great women. The elderly are doing rather well but they are facing and surrounded by an ultimate.

Assumptions

There are certain apriori notions that experience and common sense informs us are likely to cause the elderly to be a highly susceptible group for alcohol problems. These include: (1) retirement with its attendant boredom, change of role status and loss of income; (2) deaths occurring among relatives and friends and the awareness that more deaths are coming; (3) poor health and discomfort; and (4) loneliness, with a particular problem of loneliness among elderly women.

Thrown into this background is the imponderable effect created by the fact that in order to be 65 in 1980, you must have been born no later than 1915. Thus, the entire population we are discussing lived through all of the period of Prohibition not only experiencing the moral outrage which produced this social experiment but the problems engendered by its failure. Lack of knowledge of the impact of Prohibition on the people over 65 is an obstacle in trying to understand and reach the target population.

Statistics

It would be less than realistic to expect a report by an epidemiologist not to contain an unwieldy mass of statistical data, figures, numbers, etc. I will practice restraint and cite only a few rather generally accepted and available data which describe the elderly population, and emphasize the aspects that tend to make them susceptible to problems related to alcohol (3).

In 1977 one in nine or approximately 23.5 million Americans were 65 years and over. Among whites, 11 percent of the population was over 65 while among blacks 8 percent were in this age group and among Spanish surname populations the figure was approximately 4 percent. This is not necessarily a reflection on how old a population is but also reflects how young a population is since if a very high percentage is below age 20 than a smaller percentage of the total will be over age 65. The net increase per day of the population 65 years and older is approximately 1,500 people. This takes into account the number of people becoming 65 and subtracts the

deaths in the age group 65 and over. Modestly projecting to the year 2000 there will be 32 million people over the age of 65 in the United States. Currently, 45 percent of those 65 and over live in seven states. There are more than 2 million in this age group in California and New York. More than 1 million people over age 65 live in Florida, Illinois, Ohio, Pennsylvania, and Texas. There is a slight tendency for more elderly to live in rural areas. Thus, while 69 percent of those over age 65 live in metropolitan settings 74 percent of the population under 65 are metropolitan dwellers.

In 1975 about 11 percent of the elderly population lived below poverty level. Massachusetts had the lowest rate with approximately 6 percent below the poverty line while Mississippi and Georgia had the highest percentages, 37 and 32 percent respectively.

Life expectancy in the United States in 1976 was 73 years or approximately 69 years in males and 77 in females. An infant girl born today has a 50-50 chance of being 80 years old. At age 65 the subgroup with the most favorable life expectancy is the black female. Approximately 82 percent of females and only 65 percent of males survive to age 65. At age 65, the average male can expect to live another 14 years while females can expect to live another 18 years. The differential survivorship between males and females causes a potentially devastating imbalance between males and females over age 65. For every 100 males there are approximately 150 females.

In terms of living arrangements somewhere between 4 and 5 percent over age 65 are in institutions the great majority, of course, being in nursing homes. The average age in nursing homes is approximately 82 with two-thirds of the population being female. More than 25 percent of people in nursing homes have no living relatives. Among those living in the community, 1.6 million males or 17 percent of the total male population over age 65 live alone or with non-relatives. An almost staggering 5.5 million females in this age group live alone or with non-relatives or 42 percent of the total female population over 65. Because women live longer but tend to marry older men and older men who are widowed find it easier to remarry, at present over the age of 65, 77 percent of males while only 48 percent of females are married.

The present cohort age 65 and over has an average of 9.5 years of education. About one third have finished high school and 8 percent have finished college. Along with the increase in the absolute number of people age 65 and over, the median level of education is rising so that within the next few decades there will be little difference in educational level at any adult age. This has considerable significance in terms of planning since the people who will be joining the ranks of the elderly will be better educated and hence more vocal and demanding than the present constituency.

At present only 8 percent of women over age 65 are working. This is not a great departure from the past. Among men, however, only 20 percent of the population are working. In 1900, 67 percent of the male population over age 65 were employed. Leisure time, however, may be diminishing as financial needs cause more elderly to remain employed.

A total of 40 percent of people 65 or over have a serious health problem which causes some limitation in conducting normal daily activities. This compares with approximately 7 percent of the population under age 65. Each year 17 percent of those over 65 are hospitalized at least once and each hospitalization lasts for an average of 12 days. For those under 65, 10 percent are hospitalized annually for an average stay of approximately 7 days. The average annual cost for health, per capita, per year for those over age 65 is estimated to be approximately \$1,500 while for those under age 65 it is \$550.

Alcohol Issues

I would like now to return to alcohol problems and what I have referred to which would suggest that people over 65 are indeed in a high risk group. Retirement with its attendant role change, boredom and financial problems, increased concern with death and losses of relatives and friends, poor health and chronic discomfort and above all, loneliness, particularly among women, are themes which are supported by the data which I have just presented.

What is known factually about drinking in the elderly population? There are two major sources for information. The first is through surveys of the general population. Rates from various surveys suggest that the absolute number of abstainers increase and the total amount of alcohol consumed decrease with age. There are various estimates of alcoholism ranging from

about 1 to 5 percent of the population over age 65 (4) (5-review). Thus, if one was to conduct a survey in order to detect about 25 patients we would have to interview 1,000 people assuming total cooperation and candor in responses. Not knowing the effects of Prohibition etc. on this age group and giving some credence to the belief that this population and their families are inclined to deny alcohol problems this estimate of sample size may be much too low. It would appear that surveys are a costly and potentially unreliable measure of alcoholism in the elderly.

The second approach involves individuals being hospitalized or being seen by medical or paramedical personnel for any and all problems. Within this population it is estimated that 10 to 15 percent have a drinking problem which is in some way related to their present illness. Both Zimberg (6) and Schuckit (7) discuss this issue and the attendant difficulty in establishing the diagnosis of an alcohol related problem in this population. There is some evidence and a mass of observational data which indicate that alcohol has unusual affects on elderly people. They appear to be less tolerant at lower doses of alcohol and since many have heart conditions and alcohol is a cardiac muscle irritant, the role of alcohol in the patient's cardiovascular condition is difficult to detect; many patients are on other drugs which may produce reactions even with small amounts of alcohol; and finally alcohol seems to produce transient syndromes in the elderly which are indistinguishable from senile dementia. This latter is potentially tragic because a person could easily be labeled as having senile dementia

when he is suffering from a mild alcohol problem and once the diagnosis of dementia is made his chances of spending most of the rest of his life in an institution considerably increase.

Clinical

Epidemiologists soon learn that clinical observations are usually correct and research in epidemiology frequently is establishing confirmation of observations by astute clinicians. I have been most impressed by the work of Zimberg (6), Rosin and Glatt (8), and recently Schuckit (7). My job, however, is to question the observations to be sure we do not continue accepting and believing anecdotes that become well intentioned myths.

I am troubled that Rosin and Glatt and Zimberg all made their contributions in the early 1970's or before. None of their work has been expanded or repeated. Their initial reports described fewer than 200 patients and their population tended to be atypical in that they were either an excess of females, urban and from impoverished areas such as Harlem or parts of London.

Key points have emerged from their studies. These authors tend to agree that there are two broad types of elderly alcohol abusers. One is the long-term abuser or survivor who apparently has whatever mystic psychological problems which cause early alcoholism but this particular group is simply tougher and survives into old age. The estimates given are that two-thirds of the elderly alcoholics are in this group. The second group are those whose onset is late in life. In contrast to the former, these are referred to alcohol specialists

through geriatric practice rather than psychiatric practice. Their drinking is generally situational, exacerbated by failing physical and mental health, and emotional and environmental stresses.

A major claim is that elderly alcoholics, both those with early and late onset, are easier to treat than other alcoholics. It is further suggested that their treatment need not be through classic mechanisms used for younger alcoholics such as Alcoholics Anonymous (AA) and routine alcohol counseling, but is amenable to simple socialization. When in treatment programs, the elderly tend to be more responsive and more faithful in attendance. The surprising claim is that therapeutic methods, which are of little use in earlier years, are successful both for early and late onset elderly alcohol abusers. Surely it is time to stop writing reviews and quoting vintage, Zimberg, Rosin and Glatt. These assertions need repetition and proof. This is critically important since the need for treatment will grow at least in proportion to the rate of growth of the elderly population.

If these anecdotes and studies are confirmed they offer a rational modus operandi to find and treat large numbers of elderly alcoholics. As I mentioned above, it is claimed that 10 to 15 percent of elderly individuals seeking medical or paramedical attention have an alcohol problem. This should certainly be extensively investigated and confirmed since the rate of 10 to 15 percent is sufficiently high that a fairly intensive effort would yield a large number of suffering individuals. If the yield is high we must develop methods to make care givers more sophisticated so that they can diagnose the alcohol problems in the patients they see. The reason I stress the above is that if the treatment is as simple and successful as is

suggested by the classic writers then we have a relatively efficacious and available mechanism to deliver a great deal of medical and social help to a large group of people. Please note that throughout this I am emphasizing that the early studies and assumptions must be confirmed before massive programs can be embarked upon with any great sense of optimism. I would give highest priority to straight forward case finding studies in hospitalized series and to carefully documented treatment trials.

Conclusion

Finally I shall address what I consider to be the largest and potentially most rewarding approach to alcohol problems in the elderly. We have a world of anecdotal or mildly scientific observations suggesting that there are many elderly alcoholics both of the early onset and late onset categories who are easy to cure. While the rates of alcohol abuse and drinking are low and decline with advancing age, there is a very high rate among the segments of that population which is seeking medical help of all sorts.

My own anecdotes which do not appear in the literature come from people who run housing authorities in local jurisdictions or large housing projects. The stories also come from managers of retirement communities throughout the country. Since urban housing and retirement communities are becoming more numerous attention must be paid to these anecdotes. My informants tell me that their most catastrophic and persistent problem is alcoholism and alcohol abuse and an inordinately high proportion of their serious and nagging difficulties arise from this problem. The rates of alcohol associated fires, falls, starvation and neglect, and violence are simply unknown but increasingly whispered about in these communities for the elderly.

Confounding the establishment of the veracity of these anecdotes is the near impossibility of collecting accurate data. We hope to do good but can we do surveys well. There is no research in this age group concerning how to question and find reliable answers. The nuances in working include the fact that there are more women, that their attitudes were formed and influenced before Prohibition, that surveys themselves are very expensive and if the anecdotes are only partially true, it would take about a hundred interviews to find one patient given a predictably high denial rate. Some survey research should be done but my opinion is that firm data will not emanate from the age group currently under question.

It is likely that studies of the natural history and factors related to the decline in alcohol consumption with age would be rewarding, possibly in ways not immediately apparent to us now. Another promising route of investigation is to learn more about late onset problem drinkers. Case-control studies might identify who are the people at high risk and how they got there.

Finally, I would recommend that along with survey research and clinical treatment research we should contemplate prevention efforts of the type that have done relatively poorly in the adolescent and young ages. I do believe we have a much more responsive audience in the population which is now 55-64 years of age. A major prevention education effort would be of great interest to unions, management the government and anyone paying pensions or involved in health insurance. The staging would be to instruct this population that they are growing older and with age comes those risks

which we know are associated with a greater likelihood for developing and perpetuating problems with alcohol. To repeat them once again, we would educate the target population that with retirement will come less money, a change in their status and role, and lots of free time which they are not used to having. We must openly discuss the fact that death will be increasingly visible as they enter into the age when relatives and friends are passing away. We must present forcibly the information that health declines with age and that major and minor illnesses are an inevitable risk to the individual and his loved ones. Finally we must emphasize the problem of loneliness and physically living alone, particularly for women but really all elderly. Throughout this, the message to be maintained is that alcohol while tempting and abundant is very likely to make things worse. This should be accompanied by intense research to determine if and why alcohol has an exceptionally deleterious effect on aging individuals and if addiction is easily cured.

Encompassed in these suggestions are two goals; the first is obvious since we are targeting the population age 55 to 64 we are trying to prevent alcohol problems from arising after age 65. Secondly, I propose that this is a fairly effective way to reach people over age 65. This population is known to be sophisticated to the extent that they read newspapers and watch television more than most of their younger counterparts. Many of those who do have alcohol related problems will identify with the messages being presented for the younger cohort and will seek help through medical sources, AA, and other community resources. Thus, through practicing good prevention in one cohort we may be practicing good case detection in another. This is a time for research and a time for action; our problems will only be growing worse until our commitment becomes greater.

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